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Sharon P. O'Neill

University of Baltimore School of Law

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The Use of Federal Rule of Evidence 803(4) in Child Abuse Cases

by Sharon P. O'Neill

I. Introduction

Recent public awareness of child abuse¹ has brought to the forefront the problems which face the victim,² the prosecution, and the defendant at trial. Existing tensions between the Sixth Amendment right to confrontation, state interests, and the rule against hearsay with its assorted exceptions intensify when the child abuse victim discloses the perpetrator's identity during medical diagnosis and treatment. In many instances, these statements create the sole means of identifying the defendant as the guilty party. The prosecution, therefore, will often attempt to admit this evidence through the testimony of a non-declarant under Federal Rule of Evidence (hereinafter FRE) 803(4), as statements for the purposes of medical diagnosis and treatment, or an analogous state exception.³

Child abuse most often occurs in secrecy,⁴ with the child and the abuser being the only witnesses. Problems arise when the abused child fails to meet competency requirements,⁵ is unavailable for testimony, or recants testimony while on the stand.⁶ Under these circumstances, the prosecution must attempt to elicit the victim's prior statements through other witnesses under an exception to the hearsay rule.⁷

This article will focus on how statements made by the victim to

physicians, psychiatrists, or psychologists⁸ create multiple hearsay problems when they describe events or identify the perpetrator. It first will discuss background law on hearsay and Rule 803(4). Second, it will discuss the need for a hearsay exception in child abuse prosecutions. Third, it will examine the physician's and psychologist's roles in the diagnosis and treatment of the abused child. Finally, this article will examine the case law relevant to the admission of out-of-court statements made in the course of medical diagnosis and treatment which divulge the cause of the abuse or the identity of the abuser.

II. Background Law

A. Rule Against Hearsay

Hearsay is a statement made by an out-of-court declarant which is offered into evidence for its truth as to the matter asserted.⁹ Federal Rule of Evidence 801(c) defines hearsay as "a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted."¹⁰ Assertions may be either verbal or non-verbal.¹¹ In the abuse context, a child makes a verbal assertion when she speaks, writes, or responds to questions by the physician or psychologist. A non-verbal assertion occurs, for example, when in response to a question a child nods her head¹² or points

to part of her body or to that of an anatomically-correct doll.

Under this definition, non-hearsay statements would be those which are not offered for the truth of content or those made by a declarant while testifying under oath, subject to cross-examination, before the trier of fact.¹³ For instance, observations by a witness that a child has used inappropriate vocabulary or has precocious sexual knowledge could be admitted as circumstantial evidence of the child's exposure to sexual activity. These same observations, however, would be hearsay if admitted to prove their truth that the defendant abused this child.¹⁴

The rule against hearsay (hereinafter the "hearsay rule") assumes that many possible inaccurate and untrustworthy sources underlie the bare untested assertion of an out-of-court declarant. "The opponent is unable to confront and cross examine the real witness (the declarant) and to expose weaknesses in his statement."¹⁵

B. Exceptions to the Rule Against Hearsay

While cross-examination may be the best means for establishing the truth of statements made by a declarant,¹⁶ exceptions to the hearsay rule have developed at common law.¹⁷ More recently, some of these exceptions have been codified in the Federal Rules of Evidence (FRE

803 and 804),¹⁸ as well as in various state codes.¹⁹ These exceptions provide an avenue for admitting hearsay based on the assumption that "the declarant's truthfulness is . . . clear from the surrounding circumstances."²⁰ As statements admitted under these exceptions are inherently reliable and trustworthy, the test of cross-examination has "marginal utility."²¹

C. Balancing Sixth Amendment Rights with the Need for Hearsay

The Confrontation Clause of the Sixth Amendment to the United States Constitution, made applicable to the states by way of the Fourteenth Amendment, provides "[t]hat in all criminal prosecutions, the accused shall have the right . . . to be confronted with witnesses against him"²² This right encompasses three elements: (1) the right to cross-examine the witness, (2) the right to have the jury view the witness' demeanor, and (3) the right to face-to-face confrontation with the witness.²³

"The Confrontation Clause acts in tandem with the hearsay rule to afford criminal defendants the right to confront available accusatory witnesses in court, where their testimony is given under oath before the fact finder, and where the defendant may subject the testimony to searching cross-examination."²⁴ Taken literally, the Sixth Amendment prevents evidence which falls within a hearsay exception from being admitted against the accused.²⁵ The Supreme Court, however, has never interpreted the Confrontation Clause to exclude the admission of all hearsay.²⁶

Conflicts between the Sixth Amendment and hearsay can arise regardless of the availability of the declarant. When the declarant is available, she can confirm or refute hearsay admitted under an excep-

tion and then be subject to cross-examination. When the declarant is unavailable, a greater danger of faulty fact finding arises as she cannot be scrutinized under cross-examination.

In order to admit hearsay, the prosecution may need to first demonstrate the unavailability of the declarant and the necessity of the statement,²⁷ and second demonstrate that the statement bears adequate "indicia of reliability."²⁸ For the most part, however, out-of-court statements are admissible when they fall within a "firmly rooted hearsay exception" or have been shown from the totality of the circumstances to demonstrate a "particularized guarantee of trustworthiness."²⁹ Firmly-rooted exceptions would be those recognized at common law and those by rule. Those created by statute do not fall within this group, because they require the proponent to demonstrate reliability and trustworthiness.³⁰

D. Statements Made for the Purposes of Medical Diagnosis and Treatment

One firmly-rooted hearsay exception makes statements made for the purposes of medical diagnosis and treatment admissible. Under the common law,³¹ this exception excluded statements made to the non-treating physician for the sole purpose of providing testimony. This exclusion was based on the belief that such statements had no guarantee of truthfulness. Rule 803(4), however, does not differentiate between treating and non-treating physicians.³² Rule 803(4)³³ provides that:

The following are not excluded from the hearsay rule even though the declarant is available as a witness:

. . . .

(4) Statements for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain or sensation, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis and treatment.

Statements admitted under this exception relate to medical history, to bodily feelings (past or present), or to inception or general cause of the injury or the disease.³⁴ "[Rule 803(4)] does not embrace statements or parts of statements which are not reasonably pertinent" to either diagnosis or treatment.³⁵

The trustworthiness of such statements is based on two independent rationales. First, the person seeking medical attention serves her own self-interest by giving truthful information in order to receive accurate diagnosis and treatment.³⁶ Second, if a medical expert would rely on such a statement as a basis for diagnosis or treatment, the statement is reliable.³⁷ The motivation to receive proper medical attention reduces the dangers of untruthfulness. Such a declarant is less likely to (1) give an inaccurate description of intimate events, (2) have a poor recollection of bodily feelings and condition, (3) lack knowledge regarding her experience with symptoms, and (4) articulate ambiguously.³⁸

Because a motivation to promote an accurate diagnosis and treatment is crucial to the statement's reliability, no requirement exists that the statement be made to a physician.³⁹ Statements made by third parties⁴⁰ could qualify under this exception if this person has an interest in the well-being of the patient, such as a parent⁴¹ or relative.⁴² In most scenarios, a non-abusive parent would

have no motive to mislead the physician and would be able to describe the child's symptoms based on her intimacy with the child. The relationship between the declarant and the child, therefore, determines the admissibility of the hearsay.⁴³

Statements attributing fault ordinarily do not qualify under the language of Rule 803(4) unless the statement reasonably pertains to diagnosis or treatment.⁴⁴ These statements are considered less reliable because the declarant may be motivated by a desire other than to assist in diagnosis or treatment.⁴⁵

Special problems arise when statements are made to psychologists by their patients.⁴⁶ Rule 803(4) does not expressly cover statements made pertaining to the declarant's mental health. Statements made to the psychologist which are then relayed to the physician fall within the language of Rule 803(4) as "statements made for the purposes of medical diagnosis or treatment."⁴⁷ These statements, irrespective of their context, are pertinent because experts in psychology view all mental processes as being relevant to diagnosis and treatment.⁴⁸ Such statements, nevertheless, may lack reliability because the patient's mental impairment may have decreased her ability to accurately describe, recall, perceive, or clearly articulate the events.

III. The Need For Hearsay And The Use of FRE 803(4) In Child Abuse Cases

Out-of-court statements made by abused children are often essential to the state's case. These statements are admissible when the court has determined that the child is incompetent or unavailable for testimony.⁴⁹ While the state may have sufficient proof that child abuse has occurred,⁵⁰ this abuse, especially that of a sexual

nature,⁵¹ most often occurs in secret with the child being the sole person who can identify the assailant.⁵² Circumstantial evidence, therefore, becomes crucial to the state's case. This would include expert testimony, character evidence, and hearsay elicited through testimony of a physician and/or psychologist.

The use of out-of-court statements made to physicians and psychologists conflicts with the defendant's right to confrontation. In deciding whether to admit such statements, the court must strike a balance between the societal interests of protecting the child and punishing the abuser with its own role in promoting accurate fact finding.

In dealing with these out-of-court statements, the court has three options. It may refuse to admit the statement, permit the statement to come in under an established exception, or admit the statement through statutorily-created child abuse exceptions. This last option pertains to an attempt by state legislatures to deal with testimonial problems in child abuse cases. Maryland has two such exceptions: the Closed Circuit Television Exception and the Child Abuse Hearsay Exception.

The Closed Circuit Television Exception⁵³ protects an allegedly abused child from experiencing emotional trauma which would inhibit her ability to reasonably communicate before the court. After the judge determines that a child is unable to communicate in front of the defendant, the child testifies outside of the court in a room with counsel for both sides present. This room contains equipment operators, and unless the defendant objects, any person the court believes contributes to the child's well-being.⁵⁴ While this exception provides an avenue for obtaining in-court testi-

mony from the child, it also provides a means for the defendant to see the child and to question the child about statements made to the physician.⁵⁵

The Child Abuse Hearsay Exception⁵⁶ establishes limited conditions under which out-of-court statements made by abused children can be admitted for the truth of the matter asserted. To invoke this rule, the child must be either available to testify in court or by closed circuit television, or shown to be unavailable.⁵⁷

If the child is not available, the hearsay offered through this exception must not be admissible under any other exception and must be corroborated by the evidence.⁵⁸ This means the state must prove that the statement it proffers possesses "particularized guarantees of trustworthiness."⁵⁹

In a sexual abuse case where the prosecution has no corroborative evidence, the latter requirement may be most difficult to prove. When corroborative evidence does exist, the statement may be inadmissible because it had not been specifically made to a physician, teacher, social worker, or psychologist in the course of her profession.⁶⁰ The state will, therefore, use this latter exception only when it cannot get the child's statement in the record under one of the "firmly rooted" exceptions such as Rule 803(4).

Rule 803(4) is better suited for this purpose because statements admitted under this exception are assumed to be trustworthy. Conflicts between the use of Rule 803(4) and the Confrontation Clause are lessened when the child is available to testify and can refute or verify the hearsay. When the child cannot testify, this rule does not require a showing of the declarant's unavailability or proof of notice to the de-

fendant which are required under the child abuse hearsay exception.

IV. The Role of The Physician or Psychologist in Child Abuse Cases

"At a time of shortened social services and of increasing visibility of family violence, it is often the medical office or pediatric emergency department that serves as the portal of entry into the service system."⁶¹ The physician, bound by the Hippocratic oath,⁶² has a duty to diagnose and treat patients accurately. When child abuse is suspected, the physician has two obligations: (1) a duty to treat the physical and emotional consequences of abuse, and (2) a statutory duty⁶³ to report suspected abuse to authorities. Any medical history, therefore, which establishes the immediate treatment needs and raises a level of suspicion regarding the possibility of abuse should be carefully recorded.

A proper evaluation of an allegedly abused child usually includes an initial history and social assessment, a physical examination, diagnostic tests, and an investigative interview.⁶⁴ Reports of suspected abuse are made when sexual abuse has been alleged or the injury is inconsistent with the history obtained for the child's developmental age.⁶⁵

A. The Use of Child Advocacy Teams

Many hospitals have created Child Advocacy Teams⁶⁶ which take a non-partisan role in determining whether there is evidence of neglect which should be referred to the authorities.⁶⁷ This team typically includes a pediatrician, a nurse,⁶⁸ a social worker, and a psychologist or psychiatrist. Referrals most often come from within the hospital through a clinical unit or the emergency room. They may also come

from an outside referral source such as a pediatrician's office.

Once the team accepts a referral, the social worker takes an initial history and social assessment. The pediatrician or nurse practitioner⁶⁹ performs a physical examination and orders any necessary diagnostic tests. The psychologist or social worker⁷⁰ conducts an investigative interview which may include the use of anatomically-correct dolls to enable an inarticulate victim to demonstrate the event. The physician leading the team uses the information obtained by its members to diagnose the type of abuse and to establish a therapeutic plan of care.⁷¹

B. The Evaluation of the Child

The evaluation of the child consists of a medical history, a physical examination, a developmental examination, and a diagnostic evaluation.

a. Medical History

The medical history provides a means for the physician to construct a time line of salient events associated with suspected abuse. This information is obtained in separate interviews from each available parent while the child is not present. The rationale behind this tactic lies in the belief that parents⁷² and children will be less fearful of disclosing abuse when other parties are not present.⁷³ As child abuse and neglect are symptomatic of a dysfunctional family,⁷⁴ the physician must remain attentive to discrepancies between the comments of each parent and the child. Suspect comments include persistently negative characterizations of the child, disparities between each parent's view of the child, and their individual descriptions of parenting practices.

A pediatric history usually starts with neutral questions regarding the child's size at birth and attainment

of certain developmental milestones, such as putting words together at an early age. The parent is questioned about the child's behavior, with attention to recent changes in behavior. Finally, the parent is questioned about specific injuries to determine the level of risk to the child.⁷⁵

b. Physical Examination

The type of physical examination the child must undergo depends upon the original complaint that precipitated the visit to the physician. "Physicians must approach an injury as a symptom requiring a diagnosis of cause," as accidental injuries may be difficult to distinguish from non-accidental ones.⁷⁶ Though signs and symptoms of abuse may be blatant, the majority are subtle in nature.⁷⁷ The physician, therefore, must have an understanding of the common manifestations of child abuse.⁷⁸

During a routine physical examination, the physician inspects the child's body for bruising, deformities, and trauma.⁷⁹ She listens to the chest and abdomen for irregularities. She visualizes the retina of the eye to observe retinal bleeding or lesions and the oral cavity to detect mucosal lesions or dental trauma. She examines the inner ear to identify eardrum perforations and other deformities. Digital and visual examinations⁸⁰ of inner vaginal and rectal areas are performed only if there are complaints, symptoms, or suspect surface areas.

c. Developmental Examination

The physician must evaluate the child's motor skills to determine if the reported cause of an accident is consistent with the child's developmental age. Accidental injuries require the child to have certain motor capabilities. For example, a fall from a bed is not possible if the child is unable to roll over. If a sibling is blamed by the caretaker for an in-

jury, the physician must question whether it is physically and developmentally possible for the sibling to have caused the injury.⁸¹

d. Diagnostic Evaluation

Diagnostic evaluation of the child depends largely on the results of the medical history and physical obtained by the physician. The nature of the suspected injury, the possibility of abuse, and the child's age also factor into the physician's decision to order diagnostic tests. These tests may include:

1. Radiologic imaging:⁸²

In children under five years of age, bone surveys⁸³ using roentgenograms (x-rays), or more sophisticated radionuclide skeletal scintigraphy (bone scans), detect fractures and other skeletal injuries not identified with conventional x-ray techniques.

The CT/CAT scan tests can identify acute and chronic head injuries and facilitate the diagnosis of abdominal injuries.

2. Laboratory studies:

Samples of any fluids are sent to the laboratory for identification. These fluids might include semen found during an external or internal vaginal or rectal examination.

Cultures are taken if sexual abuse has been reported or to interpret the clinical findings of sexually transmitted diseases (hereinafter STD's)⁸⁴ when no sexual abuse information has been elicited from the child or parent.⁸⁵

Based on the findings of the medical history, physical, developmental evaluation, and diagnostic tests, the diagnosis of suspected abuse is made. The physician then is obligated to report this suspicion to the appropriate authorities.

C. The Role of the Psychologist

A psychologist also may play a similar role in the evaluation of an

abused child. Because a parent will not usually bring the child to a psychologist for evaluation, the psychologist ordinarily becomes involved upon referral from the physician or the child advocacy team. After the treatment of associated medical problems,⁸⁶ the psychologist then evaluates the child to ascertain and treat the psychological consequences of abuse. A variety of treatment modalities, such as therapeutic play and art, may be used to facilitate communication with the child.⁸⁷ Diagnosis and treatment may also involve an evaluation of other family members.

V. Statements as to Cause and Identity in Abuse Cases

The information obtained during medical and psychological diagnosis and treatment often provides evidence for prosecuting the abuser. The state's ability to protect the child frequently rests on the physician's or psychologist's response to the child and her ability to observe and record. Though the victim may be aware of possible criminal charges being brought against the abuser, courts have permitted hearsay testimony from physicians and psychologists regarding the cause of the abuse.⁸⁸ These same assertions, however, are inadmissible when the physician or psychiatrist performs the evaluation in preparation for impending civil litigation.⁸⁹ This is because statements made to the practitioner may have motivations other than the need for diagnosis and treatment and are, therefore, less reliable.

Rule 803(4) has been used in child abuse cases to admit into evidence those assertions made to physicians and psychologists which describe symptoms and the general cause of the abuse.⁹⁰ Dispute over the admissibility of these statements

centers around whether they meet the requirement that such statements be "pertinent to diagnosis and treatment."

A physician ordinarily may not testify under Rule 803(4) that a child told her the identity of the abuser.⁹¹ The rationale behind this rule stems from the belief that the doctor has a responsibility to diagnose and treat, rather than to investigate illegal conduct.⁹² Additionally, if the victim believes she is being asked the identity of the perpetrator, the reliability of the statement may be destroyed.⁹³ Trustworthiness does remain intact, however, when the same statement has been motivated by the desire to aid medical diagnosis and treatment.

In order for a court to admit these out-of-court statements under Rule 803(4), the child must have been able to formulate the medical problem and communicate this problem to some other person for the purposes of diagnosis and treatment.⁹⁴ Children are often too young to appreciate the necessity of truthfulness in obtaining treatment, or to understand "the relationship between their statements and receiving effective medical treatment."⁹⁵ For example, statements made during play therapy can create problems for the court. In determining admissibility, the court must first decide whether the play sessions are congruent with treatment or diagnosis. If so, the court must find that the child made the statement with an intent to assist the psychologist in diagnosis and treatment.⁹⁶

The competency of the child also plays a role in some courts' admission or exclusion of hearsay. Courts which exclude statements made by incompetent children do so based on the belief that a child who cannot appreciate the significance of truthful testimony cannot be capable of providing the physician with accu-

rate information.⁹⁷ Other courts differentiate between the trustworthiness of statements made to physicians and those made in court while testifying.⁹⁸ "The cornerstone [in these courts] is whether the statement is reasonably pertinent to diagnosis and treatment."⁹⁹

VI. Case Law

In *Idaho v. Wright*, a 1990 decision, the Supreme Court identified several factors which it believed properly relate to the reliability of out-of-court assertions made by children.¹⁰⁰ These factors include the mental state of the declarant, the use of terminology unexpected in a child of similar age,¹⁰¹ the spontaneity and repetition of the statement,¹⁰² and a lack of motivation to fabricate the statement.¹⁰³ Other considerations include, but are not limited to, the child's age, the presence of corroborating evidence, and the child's relationship to the accused and to the person to whom the statement was made.¹⁰⁴

In sexual abuse cases, questions concerning the reliability of out-of-court statements made by children center around whether the statements are intrinsically reliable. Courts which accept the intrinsic reliability of this type of hearsay justify their actions with two rationales: (1) children do not persistently lie to parents or other authority figures about sexual abuse, and (2) children have an insufficient knowledge base to lie about sexual matters.¹⁰⁵ Those courts adopting a contrary view focus on the ability of the child to tell stories and fantasize.¹⁰⁶

In recent times, state courts have split as to the admissibility of statements made to physicians pertaining to cause¹⁰⁷ or fault¹⁰⁸ in child abuse cases. Similar statements made to psychologists are on even weaker footing.¹⁰⁹ Courts admit-

ting statements made to psychologists argue that intra-family dynamics in child abuse cases create a need for a special interpretation of Rule 803(4) and its application.¹¹⁰ This belief stems from the fact that there is a proportional increase in the reoccurrence of abuse when the identified abuser is a family member.

Several federal cases have influenced the states' expansion of Rule 803(4). In *United States v. Iron Shell*, the United States Court of Appeals for the Eighth Circuit held that it was not error to allow into evidence statements made by a nine year-old child pertaining to her sexual assault.¹¹¹ The court reasoned that the victim's statements to the examining physician related to the child's physical condition and were thus consistent with a motivation for treatment.¹¹²

The *Iron Shell* court established a two-part test for determining the admissibility of hearsay under this exception. "First, is the declarant's motive consistent with the purpose of the rule; and second, whether it is reasonable for the physician to rely on the information in diagnosis or treatment."¹¹³ While the testimony elicited from the physician did not name the defendant as the assailant, the court noted that identity would rarely be sufficiently related to diagnosis and treatment.¹¹⁴

While *Iron Shell* remained within the bounds of Rule 803(4), this same court stretched these boundaries in *United States v. Renville*.¹¹⁵ In *Renville*, the victim of child abuse, during in-court testimony, recanted earlier statements identifying her father as the abuser. The treating physician, over an objection, repeated the child's statement which identified her father as the abuser. The court of appeals affirmed, finding as follows:

[A] statement by a child abuse victim that the abuser is a member of the victim's household presents a sufficiently different case from that envisaged by the drafters of [R]ule 803(4) that it should not fall under the general rule. Statements by a child abuse victim to a physician during an examination that the abuser is a member of the victim's immediate household are reasonably pertinent to treatment.¹¹⁶

This logic has been criticized because its application is problematic. For example, in *State v. Nelson*, the Wisconsin Supreme Court upheld a lower court ruling admitting a statement made by a three year-old child to her psychologist. The statement identified the child's father, Nelson, as the perpetrator of sexual abuse.¹¹⁷

Criticism of *Nelson* centers around evidence elicited on cross-examination that the child had on several occasions identified the defendant, her mother's live-in boyfriend, as the abuser.¹¹⁸ Without this statement identifying Nelson, the defendant might have been more successful in creating a real doubt in the minds of the jury that someone other than himself committed the abuse.¹¹⁹

Other state courts have taken a position contrary to *Renville* by not admitting any statements of identification under Rule 803(4). In *Sulka v. State*,¹²⁰ a three year-old girl sustained injuries when she was struck in the face with a shoe. This child identified Sulka as the assailant during a physical examination by a physician. The Alaska Supreme Court held that the identification of Sulka was not pertinent to diagnosis and treatment of the child's injuries and that the trial court denied the

defendant his right to confrontation by admitting the statements of identification.

In Maryland, the court of special appeals has published two diametrically opposed rulings on the admissibility of statements of identity in child abuse cases. In the 1988 decision of *Cassidy v. State*, argued before Judges Moylan, Wilner and Weant, the court held that statements to a physician by a two year-old that "Daddy did this" were inadmissible.¹²¹ The basis for this decision was the court's belief that the two year-old "lacked the motive or purpose which is the heart of the trustworthiness guarantee."¹²² The court further noted that, even if the declarant in this case had the requisite understanding of the nature of the medical interview, the assertion would still not have been medically related to treatment. The aim of treatment, according to the court, is to determine the need for physical measures such as surgical intervention, antibiotics, or x-rays.¹²³ The court did note, however, that identity might play a role in the treatment of a victim who contracted a communicable disease as a result of abuse.¹²⁴

In determining the inadmissibility of the identification, the court postulated that the *Renville* line of cases strained to procure the identity of the abuser into evidence. While laudable, the *Renville* court effectively ignored the state of mind of the declarant and instead turned to that of the physician. The focus became the mission of the physician. The *Renville* court moved from statements pertinent to treatment of the physical injury, to the emotional injury, to final social disposition (state reporting statutes) as being included under Rule 803(4) in child abuse cases.

In *In re Rachel T.*, a case in

opposition to *Cassidy*, Judges Wilner, Rosalyn Bell, and Pollitt upheld a circuit court ruling which permitted testimony by a physician and a psychologist as to the child's identification of the perpetrator.¹²⁵ A five year-old girl had been referred to a pediatric rape center¹²⁶ after her pediatrician discovered vaginal bleeding. The pediatrician's examination identified certain physical findings consistent with sexual abuse.¹²⁷ The child was later seen on four occasions by a psychologist.¹²⁸ She told both the psychologist and the social worker that her father was the perpetrator. These statements were excluded by the trial court pursuant to *Cassidy*.

The court of special appeals determined that the trial court erred in not admitting these statements. The court differentiated the facts of this case with *Cassidy* by stating that "[t]here is a vast difference between cognitive development of a two year-old and a child of five. From the content, one can tell that the five year-old child understood that the alleged secret she shared with her father was an important one."¹²⁹

The court first suggested that Rachel knew her statements would be used to obtain treatment and prevent future exposure to abuse. Second, it stated that the child might have been exposed to venereal disease (using the avenue left open in the *Cassidy* opinion). Third, the court postulated that if the mother's story that Rachel injured herself on a broom handle had been true, she would have needed a tetanus shot. Based on these facts, the court determined that the information obtained from the social worker and psychologist were reasonably pertinent to diagnosis and treatment, and, thus, admissible.¹³⁰

Reconciling these two cases is not an easy task. In *re Rachel T.*,

however, does fit neatly into *Cassidy's* dicta that a child's contact with a communicable disease might require the admission of such statements. The children in these cases were five and two years-old respectively, with different injuries. At this point, it is difficult to predict whether facts of a future case will be found more similar to *Cassidy* or *Rachel T.* and thus whether the statements by physicians and/or psychologists will be found admissible.

VII. Conclusion

Child abuse most often occurs in secrecy, with the abused child and the assailant being the only witnesses. In such cases, the need to admit hearsay becomes even more pressing, particularly when the child cannot testify or recant a previous statement while testifying at trial. This makes the need to admit the child's out-of-court statements crucial to the fact-finding process.

Rule 803(4), regarding statements for the purposes of medical diagnosis and treatment, provides the best avenue for admitting such evidence, because it is a "firmly-rooted exception" whose "particularized guarantees of trustworthiness" have already been established. The biggest problem with the use of this exception occurs when it is used to identify the alleged perpetrator of the abuse.

Endnotes

¹See generally Johnson, *Inflicted Injury Versus Accidental Injury*, 37 Pediatric Clinic N. Am. 791, 791-96 (1990) (discussing problems of defining child abuse and neglect).

²Buckley, *Introduction: Background and Overview of Child Abuse*, 40 U. Miami L. Rev. 5, 6 (1985).

³Thirty-three states have adopted rules similar to the Federal Rules of Evidence. These states include: Alaska (Alaska R. Evid. 101 to 1101); Arizona (Ariz. R. Evid. 101 to 1103); Arkansas

(Ark. Code Ann. § 16-41-101); Colorado (Colo. R. Evid. 101 to 1102); Delaware (Del. R. Evid. 101 to 1103); Florida (Fla. Stat. Ann. §§ 90.101 to 90.958); Hawaii (Haw. R. Evid. 100 to 1102); Idaho (Idaho R. Evid. 101 to 1103); Louisiana (La. Code Evid. Ann. arts. 101 to 1103); Maine (Me. R. Evid. 101 to 1102); Michigan (Mich. R. Evid. 101 to 1102); Minnesota (Minn. R. Evid. 101 to 1101); Mississippi (Miss. R. Evid. 101 to 1103); Montana (Mont. R. Evid. 100 to 1008); Nebraska (Neb. Rev. Stat. § 27-101-1103); Nevada (Nev. Rev. Stat. §§ 47.020 et seq.); New Hampshire (N.H. R. Evid. 100 to 1003); New Mexico (N.M. R. Evid. 101 to 1102); North Carolina (N.C. R. Evid. 101 to 1102); Ohio (Ohio R. Evid. 101 to 1103); Oklahoma (Okla. Stat. Ann. §§ 2101 to 3103); Oregon (Or. Rev. Stat. §§ 40.010 to 40.585); Rhode Island (R.I. R. Evid. 100 to 1008); South Dakota (S.D. Codified Laws Ann. §§ 119-1 to 119-18-8); Texas (Tex. R. Evid. 101 to 1008); Utah (Utah R. Evid. 101 to 1103); Vermont (Vt. R. Evid. 101 to 1103); Washington (Wash. R. Evid. 101 to 1103); West Virginia (W. Va. R. Evid. 901.01 to 911.02); Wyoming (Wyo. R. Evid. 101 to 1104). Unif. R. Evid. 13(a) (Supp. 1990).

⁴See American Ass'n For Protecting Children, *Highlights of Official Child Neglect and Abuse Reporting 1985*, 3, 18 (1987) (annual reports of abuse made to designated public agencies rose from 669,000 to 1.9 million between the years 1976 and 1985, with 11.7% of the cases in 1985 involving allegations of sexual abuse).

⁵Measures of competency to testify include:

(1) present understanding of differences between truth and falsity, as well as an appreciation of the obligation or responsibility to speak the truth;

(2) mental capacity to observe or receive accurate impressions of the occurrence at the time in question;

(3) sufficient memory to retain an independent recollection of the observations; and,

(4) true capacity to communicate or translate events from memory into words as well as the capacity to understand simple questions regarding the

occurrence.

Whitecomb, Shapiro & Stellwagen, When the Victim is a Child: Issues for Judges and Prosecutors, 1985 Nat'l Inst. of Justice, Office of Development, Testing and Dissemination 33.

⁶See Note, *The Young Victim as Witness for the Prosecution: Another Form of Abuse?*, 89 Dick. L. Rev. 721 (1985) (discussing the problems facing victims who testify at criminal proceedings); Summit, *The Child Abuse Accommodation Syndrome*, 7 Child Abuse & Neglect 177 (1983) (arguing that the abused child, who recants, has not been lying, but rather succumbs to pressure from family members).

⁷This paper focuses on the use of Fed. R. Evid. 803(4) in child abuse prosecutions; however, the courts have admitted statements which identify the abuser under other hearsay exceptions. These exceptions include the following:

(1) Excited utterance. Fed. R. Evid. 803(2);

(2) Recorded recollection. Fed. R. Evid. 803(5);

(3) Record of regularly conducted activity. Fed. R. Evid. 803(6);

(4) Residual exception. Fed. R. Evid. 803(24); See *State v. Dollinger*, 568 A.2d 1058 (Conn. App. Ct. 1990) (statements identifying abuser made by child to mother and mother's boyfriend admissible under FRE 803(24)).

(5) Statutory exception in child abuse ("tender years" exception) (e.g. Md. Cts. & Jud. Proc. Code Ann. § 9-103.1 (1989)).

For a discussion of the use of these exceptions in child abuse cases see Meyers, *Hearsay Statements by the Child Abuse Victim*, 38 Baylor L. Rev. 775, 855-910 (1986) [hereinafter Myers, *Child Abuse*] (gives a comprehensive discussion of the excited utterance, statements for purposes of medical diagnosis or treatment, residual and child sexual abuse exceptions to the hearsay rule); Note, *A Comprehensive Approach to Child Hearsay Statements in Sex Abuse Cases*, 83 Colum. L. Rev. 1744, 1753-66 (1983) [hereinafter Note, *Comprehensive Approach*] (discusses judicial approaches to child hearsay which include excited utterance, residual, and statutory exceptions in child sexual

abuse cases); McLain, *Maryland's Statutory Hearsay Exception for Reliable Statements by Alleged Child Abuse Victims: A Hesitant Step Forward*, 17 U. Balt. L. Rev. 1 (1987) [hereinafter McLain, *Maryland's Statutory Hearsay Exception*] (critiques Maryland's hearsay exception for out-of-court statements made by child abuse victims).

⁸A psychiatrist is a physician who practices in the treatment and prevention of mental disorder. Dorland's Medical Dictionary 1291 (27th ed. 1988). As a licensed physician, this practitioner can prescribe medication in conjunction with therapy. *Id.*

A psychologist, on the other hand, is qualified as a specialist on the basis of her study of relationship of human behavior and mental process. *Id.* at 1384. A psychologist can not prescribe medications. She may work with a physician when medication is warranted to control symptoms associated with certain mental conditions. *Id.*

Either a psychologist or a psychiatrist could help a child deal with the emotional *sequelae* of abuse.

⁹For a discussion on hearsay, see generally G. E. Lilly, *An Introduction to the Law of Evidence* (2d ed. 1987) [hereinafter Lilly]; McCormick on Evidence (3d ed. 1984) [hereinafter McCormick]; L. McLain, *Maryland Evidence* (1987) [hereinafter McLain, *Maryland Evidence*]; J. Weinstein & M. Berger, *Weinstein's Evidence* (1985) [hereinafter Weinstein].

¹⁰The Federal Rules of Evidence are applicable only to child abuse which occurs in federal enclaves (such as Indian reservations); however, these rules have served as a model for thirty-three states. See *supra* note 3.

Maryland common law defines hearsay "as parol testimony or written evidence of an out-of-court statement offered to prove the truth of the matter therein and thus resting for its value upon the credibility of the out of court declarant." 6 McLain, *Maryland Practice* § 801.1 at 271 (1987).

¹¹Silence or inaction is another form of hearsay when offered for the truth of its assertion. For example, if a person fails to respond to an apparent accusation asked by an investigator, one might

believe that the lack of response indicates that the accusation is true. McCormick, *supra* note 9, § 270, at 799.

¹²See *State v. Bawdon*, 386 N.W.2d 484, 487 (S.D. 1986) (holding that a non-verbal assertion was made when six year old child nodded head affirmatively to a question. The physician had asked, "did anyone touch you down there in the genital area?"); Myers, *Child Abuse*, *supra* note 7, at 782 n. 14.

¹³Myers, *Child Abuse*, *supra* note 7, at 779-80 (citation omitted).

¹⁴See *In re Cheryl H.*, 153 Cal. App. 3d 1098, 200 Cal. Rptr. 789, 808 (1984) (holding that a child's involuntary recoiling at the mention of her father's name was non-assertive conduct; the same gesture would have been hearsay if the child had intended to convey a specific message).

¹⁵Lilly, *supra* note 9, at 182-82.

¹⁶5 Wigmore, *Evidence in Trials at Common Law* 12 (J. Chadbourn rev. 1974) [hereinafter Wigmore] ("cross-examination" is beyond a doubt the greatest legal engine ever invented for the discovery of the truth").

¹⁷*Id.* at 158. One author has identified forty exceptions at common law. D. Binder, *Hearsay Exception Handbook* (2d ed. 1983).

¹⁸The Federal Rules of Evidence provide twenty-four exceptions which can be utilized irrespective of the declarant's availability for cross-examination. See Fed. R. Evid. 803. Five additional exceptions can be used only when the declarant is unavailable. See Fed. R. Evid. 804.

¹⁹Examples of legislatively enacted exceptions include the residual or "catch-all" exception in Fed. R. Evid. 803(24) and Maryland's "tender years" exception for out of court statements of child abuse victims in Md. Cts. & Jud. Proc. Code Ann. § 9-103.1 (1989).

²⁰*Idaho v. Wright*, 58 U.S.L.W. 5036, 5040 (1990).

²¹*Id.*

²²Maryland grants a parallel right "[t]hat in all criminal prosecutions, every man hath a right . . . to be confronted with witnesses against him . . . ; to examine the witnesses for and against him under oath . . ." Md. Dec. Rts., art. XXVII.

²³Myers, *Child Abuse*, *supra* note 7, at 823-24.

²⁴*Id.* at 823.

²⁵5 Weinstein, *supra* note 9, § 800[04].

²⁶*Ohio v. Roberts*, 448 U.S. 56, 64 (1980).

²⁷The hearsay exceptions in Fed. R. Evid. 803 do not require the proponent of hearsay to show the unavailability of the declarant; however, Fed. R. Evid. 804 exceptions do require this showing.

²⁸*Wright*, 58 U.S.L.W. at 5038.

²⁹*Roberts*, 448 U.S. at 66.

³⁰Legislatively-enacted exceptions which require the proponent of hearsay to demonstrate the reliability and trustworthiness include the residual or "catch-all" exception in Fed. R. Evid. 803(24) and Maryland's tender years exception for "out of court statements of child abuse victims." Md. Cts. & Jud. Proc. Code Ann. § 9-103.1 (1989).

³¹Because Maryland continues to recognize the common law view, only statements which are "pathologically germane" and relevant to treatment are admitted under this exception. 6 McLain, *Maryland Evidence*, *supra* note 9, § 803(4).1 at 367. Statements made to a physician engaged as an expert for litigation are admissible if they were used as a basis for opinion, but are not admissible for the truth of their assertion. *Beahm v. Shortall*, 279 Md. 321, 368 A.2d 1005 (1977).

³²The advisory committee for the rules concluded that the jury often does not distinguish between facts admitted for their truth and those which serve as the basis for the expert witness's opinion. Weinstein & Berger, *supra* note 9, § 803(4)[01]; see also *United States v. Iron Shell*, 633 F.2d 77, 83 (8th Cir. 1980) (discussing liberalized approach taken by the Fed. R. Evid. 803(4)).

While the majority of courts have adopted some form of the Rule 803(4), other courts continue to distinguish between statements made to physicians consulted for treatment and those consulted in anticipation of litigation. These courts fall into one of three groups:

(1) Courts holding that statements made by the declarant are not admissible as substantive evidence of pain or

symptoms. A patient seeking legal redress has more of an incentive to enhance symptoms.

(2) Courts holding that a physician consulted for treatment may not recant history obtained from the declarant as a basis for the truth of the history's assertion. Courts utilizing this restriction admit such statements for the limited purpose of explaining how the physician reach an opinion.

(3) Courts limiting testimony of physician consulted for subsequent testimony to objective facts which the witness has personally observed or to hypothetical questions asked while testifying.

McCormick, *supra* note 9, § 293 at 841-42 (citations omitted).

³³The need to admit statements made to treating physicians has long been recognized in Maryland. *Cassidy v. State*, 74 Md. App. 1, 27, 536 A.2d 666, 679 (1988). Out-of-court statements admissible under this exception can relate to past and present symptoms, pains or sensations. Additionally, they must be "pathologically germane" and relevant to treatment. 6 McLain, *Maryland Evidence*, *supra* note 9, § 803(4).1 at 367.

³⁴*United States v. Iron Shell*, 633 F.2d 77 (8th Cir. 1980), cert. denied 450 U.S. 1001 (1981).

³⁵6 McLain, *Maryland Evidence*, *supra* note 9, § 803(4).2 at 370-71.

³⁶Capra, *Hearsay Exceptions in Child Abuse Prosecutions*, 1 N.Y.L.J. 7 (Oct. 13, 1989); see generally Mosteller, *Child Sexual Abuse and Statements Made for the Purpose of Medical Diagnosis or Treatment*, 67 N.C. L. Rev. 257 (1989) [hereinafter Mosteller, *Child Sexual Abuse*].

³⁷Capra, *supra* note 36, at 7 col. 2.

³⁸Whitecomb, *supra* note 5, at 33.

³⁹Fed. R. Evid. 803(4) advisory committee's note ("Statements to hospital attendants, ambulance drivers, or even members of the family might be included."); see *State v. Maldonado*, 536 A.2d 600 (Conn. Ct. App. 1988) (holding as pertinent to medical diagnosis and treatment statements made by a three and a half year-old girl to a hospital security guard in spanish); *Roberson v. State*, 370 S.E.2d 661 (Ga.

Ct. App. 1988) (holding as pertinent to patient history statements made to nurse practitioner about sexual molestation). *But see Leatherwood v. State*, 548 So. 2d 389 (Ms. 1989) (holding that statements made to a qualified expert in child behavior services were not "generically medical," and, therefore, not within Rule 803(4)); *Hall v. State*, 539 So. 2d 1338 (Ms. 1989) (holding inadmissible statements to abuse counselors because such persons are not physicians and do not render medical treatment).

⁴⁰Statements to third parties that a person made a statement constitute hearsay within hearsay, or "double hearsay." In other words, the statement by a mother to a pediatrician that her daughter said "my stomach hurts" is hearsay. The pediatrician's testifying that the mother said "my daughter said 'my stomach hurts'" is also hearsay. In this situation, the court could assume that the mother has a motivation to repeat truthfully what the daughter's statement.

⁴¹*State v. Justiniano*, 740 P.2d 873 (Wash. Ct. App. 1987).

⁴²Graham, *Hearsay Exceptions - Medical Diagnosis or Treatment*, 24 Crim. L. Bull. 167 (1987) [hereinafter Graham, *Hearsay Exceptions*] (arguing against the approach professes that trustworthy statements are those which are reasonably pertinent to diagnosis and treatment; he believes that children who identify the perpetrator are not seeking treatment or prevention from the health care provider).

⁴³Weinstein, *supra* note 9, § 803(4)[01] at 145.

⁴⁴Fed. R. Evid. 803(4) advisory committee's note. For example, a statement made by a child that a car hit him would qualify, but a statement that the driver failed to obey a traffic sign would not.

⁴⁵Note, *A Child's Statements Naming an Abuser Are Admissible Under the Medical Diagnosis or Treatment Exception to the Hearsay Rule*, 53 U. Cin. L. Rev. 1155, 1158 (1984).

⁴⁶Annotation, *Admissibility of Statements Made for Purposes of Medical Diagnosis or Treatment as Hearsay Exception Under Rule 803(4) of the*

Federal Rules of Evidence, 55 A.L.R. Fed. 689, 694 (1980).

⁴⁷Weinstein, *supra* note 9, § 803(4)[01] at 150.

⁴⁸*Id.*

⁴⁹McLain, *Maryland's Statutory Exception*, *supra* note 7, at 8.

For a discussion of the problems associated with child testimony in abuse cases see generally Christiansen, *The Testimony of Child Witnesses: Fact, Fantasy, and the Influence of Pretrial Interview*, 62 Wash. L. Rev. 705 (1987) (discussing the interplay between the child's ability to remember and accurately recall as it relates to pretrial interviews and in court testimony); Feher, *The Alleged Molestation Victim, the Rules of Evidence, and the Constitution: Should Children Really be Seen and Not Heard?*, 14 Am. J. Crim. Law 227 (1988) (exploring difficulties in child testimony from the defendant's perspective).

⁵⁰This problem increases when no physical traces of abuse exist, or when "the child is very young and is directly or indirectly the principal witness against the abuser, and the case involves incest, pitting the child against the parent." *Nelson v. Farrey*, 874 F.2d 1222, 1224 (7th Cir.), *cert. denied* 110 S.Ct. 855 (1989).

⁵¹Sexual abuse differs from that of sexual assault. Sexual abuse occurs when a person responsible for the well-being of the child acts as the aggressor. Sexual assault, on the other hand, occurs when an unknown perpetrator acts as the aggressor. Physicians are required to report sexual abuse, but not sexual assault, even though both constitute a criminal offense. Paradise, *The Medical Evaluation of the Sexually Abused Child*, 37 Pediatric Clinic of N. Am. 839, 840 (1990).

⁵²McLain, *Maryland's Statutory Exception*, *supra* note 7, at 1.

⁵³Md. Cts. & Jud. Proc. Code Ann. § 9-102 (1989).

⁵⁴*Id.*

⁵⁵The United States Supreme Court in *Maryland v. Craig*, 110 S. Ct. 3157, 58 U.S.L.W. 5044 (1990), rejected the argument that this exception violates the defendant's sixth amendment right of face-to-face confrontation. While

face-to-face confrontation is preferred, confrontation is not "an indispensable element of the sixth amendment right to face one's accuser." *Id.* at 5047.

⁵⁶Md. Cts. & Jud. Proc. Code Ann. § 9-103.1 (1989); see McLain, *Maryland's Statutory Hearsay Exception*, *supra* note 8. *But see* Comment, *Confronting Victims of Sex Abuse: The Unconstitutionality of Sexual Abuse Hearsay Exception*, 7 U. Puget Sound L. Rev. 387 (1984) (argues that a similar Washington state statute conflicts with the defendant's right to confrontation under the sixth amendment).

The Court of Special Appeals of Maryland recently interpreted this statute as not pertaining solely to abuse of a sexual nature. *Cole v. State*, 83 Md. App. 279, 574 A.2d 326 (1990).

⁵⁷Under this statute, unavailability must be due to the following:

1. The child's death;
2. The child's absence from the jurisdiction, for good cause shown, and the state has been unable to procure the child's presence by subpoena or other reasonable means;
3. The child's serious physical disability; or
4. The child's inability to communicate about the alleged offense due to serious emotional distress.

Md. Cts. & Jud. Proc. Code Ann. § 9-103.1 (c)(2)(i)(1-4) (1989).

⁵⁸*Id.* § 9-103.1 (c)(2)(ii)(iii).

⁵⁹*Wright*, 58 U.S.L.W. at 5040.

⁶⁰Md. Cts. & Jud. Proc. Code Ann. § 9-103 (b)(2)(i-ii) (1989).

Children who break the shroud of secrecy covering sexual abuse may seek help from persons who do not come within these requirements. McLain, *Child Hearsay Exception*, *supra* note 7, at 30.

⁶¹Newberger, *Pediatric Interview Assessment of Child Abuse*, 37 Pediatric Clinics N. Am. 943, 945 (1990).

⁶²"I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone." Hippocratic oath, *noted in* Dorland's Medical Dictionary 768 (27th ed. 1988).

⁶³Md. Fam. Law Code Ann. § 5-704

(Supp. 1990).

A study performed in New York state examined reports of child abuse during the year 1985. It revealed that persons who have been mandated by law to report suspected abuse were 13% more likely to make reports. This study also discovered that reports involving female victims were more likely to be substantiated than those involving male victims. Eckenrode, Munsch, Powers & Doris, *The Nature and Substantiation of Official Sexual Reports*, 12 Child Abuse and Neglect 311 (1988).

⁶⁴L. Wissow, *Child Advocacy for the Physician* 45-65 (1988).

⁶⁵Johnson, *supra* note 1, at 811.

⁶⁶See generally Moore, *The Medical Diagnosis and Treatment Exception to Hearsay - The Use of the Child Protection Team in Child Sexual Abuse Prosecutions*, 13 Ky. L. Rev. 51 (1990).

⁶⁷Interview with Larry Wissow, M.D. M.P.H., Director of Child Advocacy, Johns Hopkins Hospital, Baltimore, Md. (Oct. 6, 1990).

⁶⁸See *State v. Butler*, 766 P.2d 505 (Wash. Ct. App. 1989) (holding admissible statements to nurse admitting child to hospital, under Rule 803(4), because they were used by the physician to determine the cause and the "external source" of the injury); *Goldade v. State*, 674 P.2d 721 (Wyo. 1983) (holding admissible statements identifying perpetrator to a nurse under "medical diagnosis and treatment" exception to the hearsay rule). *But see People v. Kosters*, 438 N.W.2d 651 (Mich. Ct. App. 1989) (holding that statements made to nurse were not pertinent to diagnosis and treatment; admission of this evidence was held to be harmless error due to other overwhelming evidence of the defendant's guilt).

⁶⁹*Roberson v. State*, 370 S.E.2d 661 (Ga. Ct. App. 1988) (statements made to nurse practitioner about sexual molestation held to be pertinent to patient history while statements as to the identity not admissible).

⁷⁰See *United States v. DeNoyer*, 811 F.2d 436 (8th Cir. 1987) (statements to social worker by five year-old regarding sodomy as cause of injury was admissible under Fed. R. Evid. 803(4)); *State v. Oldsen*, 732 P.2d 1132 (Colo.

1986) (statements to social worker admissible under Fed. R. Evid. 803(4)); *State v. Jones*, 367 S.E.2d 139 (N.C. Ct. App. 1988) (statements to social worker identifying perpetrator aided in medical evaluation and diagnosis of child's physical and behavioral problems; this court recognized that child had been taken to social worker at recommendation of physician and prosecuting attorney). *But see Hall v. State*, 539 So. 2d 1338 (Miss. 1989) (holding that statements made to a clinical social worker not admissible under Mississippi's version of Fed. R. Evid. 803(4)).

⁷¹See *In re Rachel T.*, 77 Md. App. 20, 36, 549 A.2d 27, 35 (1988) (holding that it was reasonable for a pediatrician to use a team approach when children are unwilling to talk in order to obtain information to make a diagnosis and to prescribe treatment).

⁷²In many cases, abused children have only one parent or relatives who act as caretakers. The persons responsible for the child's care would then be interviewed.

⁷³Newberger, *supra* note 61, at 946.

⁷⁴American Medical Association, *Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect*, 254 JAMA 797 (1985). The identifiable characteristics of families who abuse or neglect children include the following: (1) low family incomes (statistics to this effect may be skewed as a result of under-reporting of middle and upper-class abuse), (2) social isolation, (3) spousal abuse, (4) parents abused as children, (5) parents whose expectations for children are inconsistent with the child's abilities, and (6) the presence of social stressors (alcohol, drugs, mental illness, and inadequate living conditions). *Id.*

⁷⁵*Id.* at 798.

⁷⁶Johnson, *supra* note 1, at 811.

⁷⁷See generally Reece, *Unusual Manifestations of Child Abuse*, 37 Pediatric Clinics of N. Am. 905 (1990) (discussing unusual forms of abuse such as pepper aspiration, intentional microwave burns and cocaine).

⁷⁸Johnson, *supra* note 1, at 800.

In one study of 616 children reported for physical abuse during the years 1980-1982, the most common causes

of physical abuse were belts (23%), open hands (22%) (choked, grabbed, pinched, or slapped), fists (11%), propulsion (8%) (thrown, pushed, pulled, dropped or dragged), and objects (28%) (stick, paddle cord, hot liquid, heater, stove, cigarette, etc.). The cause of abuse was unknown in the remaining cases (23%). Johnson & Showers, *Injury Variables in Child Abuse*, Child Abuse & Neglect 207-15 (1985).

⁷⁹This head to toe assessment may establish inconsistencies in the history given by the child or the care giver. It may also reveal evidence of prior abuse such as old scars caused by human bites, cigarette burns, forced contact with a hot object (such as an iron), general neglect (such as poor skin hygiene), malnutrition or failure to thrive, and/or soft tissue swelling. Yaster & Haller, *Multiple Trauma in the Pediatric Patient*, 2 Textbook of Pediatric Intensive Care 1265, 1312-13 (M. Rodgers ed. 1987).

⁸⁰Internal examinations may include the use of a speculum or a colposcope:

1. A speculum examination is painful, and therefore used only when there has been evidence of bleeding from an internal source or a penetrating wound. Paradise, *supra* note 51, at 845.

2. Colposcopic examinations require the use a colposcope which provides the physician with a magnified view of the child anatomy. The examiner can record the results of this examination through the use of an attached camera. McCann, *Use of the Colposcope in Child Sexual Abuse Examinations*, 37 Pediatric Clinics of N. Am. 839 (1990). *But see De Jong & Rose, Frequency and Significance of Physical Evidence in Legally Proven Cases of Child Sexual Abuse*, 84 Pediatrics 758 (1989) (demonstrating that in 115 cases of reported sexual penetration there was no difference in the conviction rates with or without the use of colposcopy).

⁸¹Johnson, *supra* note 1, at 806. The physician may have to evaluate the sibling to see if the cause attributed to her is physically possible. *Id.*

⁸²Merten & Carpenter, *Radiologic Imaging of Inflicted Injury in the Child Abuse Syndrome*, 37 Pediatric Clinics of N. Am. 815 (1990); Wissow, *supra*

note 64, at 57.

⁸³Serial blows to young children can result in characteristic patterns of healed fractures. Evidence of this form of abuse was first published in 1962. Kempe, Silverman & Steele, *The Battered Child Syndrome*, 181 JAMA 17 (1962).

⁸⁴Offending organisms which suggest sexual abuse most frequently include gonorrhea and chlamydia, and less frequently include genital herpes or warts. As the risk of Human Immunodeficiency Virus (HIV) is extremely small, a screen for HIV is done only on request of the child's parents. Paradise, *supra* note 51, at 853.

⁸⁵Paradise, *supra* note 51, at 849-50.

⁸⁶In the alternative, a specially trained social worker may conduct the evaluation and develop a plan of care to deal with the child's specific needs.

⁸⁷*See State v. Oliver*, 354 S.E.2d 527 (N.C. Ct. App. 1987) (holding reasonably related to diagnosis drawings and oral statements made by a mentally retarded 16 year-old girl during interview with psychologist).

⁸⁸*State v. Herbert*, 480 A.2d 742, 749 (Me. 1984) (a 13 year-old girl's knowledge of possible criminal proceedings did not detract from the trustworthiness of her statement that she had engaged in sexual activity with an adult).

⁸⁹In one case, the court refused to admit statements made to a physician because the visit to her was precipitated by the mother's concern that the child had fabricated the alleged assault. *State v. Woods*, 546 A.2d 1072 (N.H. 1988). The child had no physical symptoms and offered no complaints of pain. The statements made were not pertinent to diagnosis and treatment and therefore were inadmissible.

⁹⁰*See People v. Galloway*, 726 P.2d 249 (Colo. Ct. App. 1986) (information obtained from sexually assaulted seven year-old boy as to nature of assault was needed to perform a "proper evaluation").

⁹¹McLain, *Maryland's Statutory Exception*, *supra* note 7, at 5; but *see State v. Gray*, 502 So. 2d 114 (La. 1987) (holding that a six year-old child's statement that mother hit her with a hammer was integral part of doctor's examina-

tion).

⁹²Meyers, *Hearsay and Child Abuse*, *supra* note 7, at 892.

⁹³*State v. Smith*, 337 S.E.2d 833, 840 (N.C. 1985).

⁹⁴*State v. Boston*, 545 N.E.2d 1220, 1234 (Ohio 1989).

⁹⁵*State v. Robinson*, 735 P.2d 801, 809 (Ariz. 1987).

⁹⁶Capra, *supra* note 36, at 7, col. 3.

⁹⁷*Id.* at 29, col. 3.

⁹⁸*See Oldsen v. People*, 732 P.2d 1132 (Colo. 1986) ("a finding that a child is incompetent to testify does not automatically render inadmissible all hearsay statements of the child, as long as the reliability of the statements is ensured by circumstances bringing them within the scope of an exception to the hearsay rule"); *see also State v. Miller*, 539 N.E.2d 693 (Ohio Ct. App. 1988) (holding that competency of a child is not a condition precedent to admissibility of statements made to a physician under Rule 803(4)); *State v. Goldade*, 674 P.2d 721 (Wyo. 1983), (holding that child can be competent when making statements to physician and later be found to be incompetent to testify in court), *cert. denied* 467 U.S. 1253 (1984).

⁹⁹*State v. Miller*, 539 N.E.2d 693, 698 (Ohio Ct. App. 1988).

¹⁰⁰*Wright*, 58 U.S.L.W. at 5040.

In *Wright*, a mother and her boyfriend were convicted for the sexual abuse of her two girls, ages five and one-half and two and one-half years. Ms. Wright appealed a conviction for the abuse of the younger child. This conviction rested on hearsay testimony from the treating physician. The two and one-half year-old was not competent to testify at trial. The Court reversed, finding that Wright's right to confrontation had been violated and that the statements did not qualify under any exception to the hearsay rule. The Court made this finding based on its conclusion that the child's statements to the physician lacked a "particularized guarantee of trustworthiness."

¹⁰¹*Morgan v. Foretich*, 846 F.2d 941, 948 (4th Cir. 1988).

¹⁰²*State v. Sorenson*, 421 N.W.2d 77, 85 (Wis. 1988).

¹⁰³*State v. Robinson*, 735 P.2d 801, 811 (Ariz. 1987).

¹⁰⁴*State v. Boston*, 545 N.E.2d 120, 123-28 (Ohio 1989).

¹⁰⁵Note, *Comprehensive Approach*, *supra* note 7, at 1751.

¹⁰⁶*Id.* *See also Sulka v. State*, 717 P.2d 394, 401 (Alaska Ct. App. 1986) (arguing that in younger children there exists a possibility that the child may be subject to suggestion).

¹⁰⁷*Sexton v. Alabama*, 529 So. 2d 1041 (Ala. Crim. App. 1988) (holding that since the child testified to the same information at trial, statements that the child had complained about sodomies assisted the physician in determining medical treatment); *Sulka v. State*, 717 P.2d 394 (Alaska Ct. App. 1986) (holding that the inception or general cause of trauma was admissible); *People v. Galloway*, 726 P.2d 249 (Colo. Ct. App. 1986) (holding admissible statements obtained through questioning, by physician, were part of a "proper evaluation"); *State v. Gray*, 502 So. 2d 1114 (La. Ct. App. 1987) (holding admissible a child's statements that injuries were caused by a beating with a hammer); *State v. Herbert*, 480 A.2d 742 (Me. 1984) (holding that injuries sustained by the victim warranted question by physician regarding the nature of sexual activity with an adult); *Commonwealth v. Comtois*, 506 N.E.2d 503 (Mass. 1987) (holding statements made by children to pediatrician concerning sexual abuse during an examination were admissible); *State v. Reynolds*, 378 S.E.2d 557 (N.C. Ct. App. 1989) (holding that statement describing events surrounding vaginal penetration was relevant to providing an examination of the child); *State v. Drake*, 761 P.2d 879 (Okla. Crim. App. 1988) (holding that the lower court properly admitted statements after an in-camera hearing had been held to determine if the statements as to cause were pertinent to diagnosis and treatment); *State v. Bowden*, 386 N.W.2d 484 (S.D. 1986) (holding that trial court correctly admitted testimony that a child nodded her head to questions asked during a physical examination). But *see State v. Robinson*, 735 P.2d 801 (Ariz. 1987) (holding that a statement as to cause

had not been elicited to further diagnosis or treatment).

¹⁰⁸*See Stallnacker v. State*, 715 S.W.2d 883 (Ark. Ct. App. 1986) (holding admissible statement identifying perpetrator as, the identification was pertinent to preventing the recurrence of the abuse and in the treatment of child who had been abused at home); *State v. Dollinger*, 568 A.2d 1058 (Conn. Ct. App. 1990) (holding that the identity of the abuser is pertinent when the abuser is a member of the child's household; this information facilitates treatment of physical and psychological injuries); *State v. Gray*, 502 So. 2d 1114, 1117 (La. Ct. App. 1987) (holding admissible a child's statement that her mother had beaten her with a hammer because such information was an "integral part of the examination"); *State v. Larson*, 453 N.W.2d 42 (Minn. 1990) (holding that statements identifying father as abuser were pertinent to treatment); *State v. Aguillo*, 350 S.E.2d 76 (N.C. 1986) (holding that identity of perpetrator was relevant to providing a safe environment for the victim); *State v. Reynolds*, 378 S.E.2d 557 (N.C. App. Ct. 1989); *State v. Miller*, 589 N.E.2d 693 (Ohio Ct. App. 1988) (admitting statement by child to physician which identified father as assailant); *State v. Roberts*, 775 P.2d 342 (Or. Ct. App. 1989) (holding statements identifying mother pertinent to medical and psychological treatment); *State v. Sorenson*, 421 N.W.2d 77 (Wis. 1988) (holding that statement in which the child identified uncle as the abuser was admissible through physician's testimony because it was pertinent to making a diagnosis of the physical and emotional condition of a child repeatedly sexually abused); *Goldade v. State*, 674 P.2d 721 (Wyo. 1983) (holding identity of abuser was pertinent to medical treatment and consistent with public policy of protecting children from abuse); *Stephens v. State*, 774 P.2d 60 (Wyo. 1989) (holding that the proper foundation must be laid for statements as to fault or causation to be admitted). But see *Sulka v. State*, 717 P.2d 394 (Alaska Ct. App. 1986) (holding that the identity of the assailant was not admissible under Fed. R. Evid.

803(4), as such testimony violates the defendant's right to confrontation); *W.C.L. v. People*, 685 P.2d 176 (Colo. 1984) (holding that statements identifying uncle as abuser were not pertinent to diagnosis or treatment because the child was referred to the physician solely for the purpose of expert testimony in criminal proceedings); *State v. Conn*, 451 N.W.2d 555 (Mich. Ct. App. 1990) (holding inadmissible statements of identification by a seven year-old); *State v. Camele*, 360 S.E.2d 307 (S.C. 1987) (holding inadmissible statements by child to doctor in which the child said that neither his mother nor his stepfather had committed the abuse was not admissible; the court additionally held that statements that the defendant had committed fellatio upon him were inadmissible; both of these statements did not assist the doctor in determining whether the child had been sexually abused).

¹⁰⁹*See State v. Robinson*, 735 P.2d 801 (Ariz. 1987) (holding admissible statements as to cause and identity of the abuser; the psychologist testified that these statements were made during the course of treatment and were crucial to effective diagnosis and treatment); *State v. Larson*, 453 N.W. 2d 42 (Minn. 1990) (holding that statements to a psychologist which identify the abuser are admissible as they are pertinent to treatment); *State v. Altgilbers*, 786 P.2d 680 (N.M. Ct. App. 1989) (holding that a statement of identity bears on the child's self perception and her relationship to the assailant); *Macias v. State*, 776 S.W.2d 255 (Tex. Ct. App. 1989) (holding admissible statements made for the purpose of medical diagnosis and treatment which were in a psychologist's report; the child had stated that the defendant had sexually abused her by inserting his fingers into her vagina); *State v. Nelson*, 406 N.W.2d 385 (Wis. 1987) (holding admissible statements identifying father as abuser as pertinent to diagnosis and treatment by two psychologists); *Stephens v. State*, 774 P.2d 60 (Wyo. 1989) (holding that statements of identity given to psychotherapist must have been relied upon for treatment or diagnosis). But see *Ward v. State*, 368 S.E.2d 139 (Ga.

Ct. App. 1988) (holding that statements identifying the perpetrator were admissible only as they pertain to the psychologist's opinion as an expert, but not admissible if offered solely as a statement made for purposes of diagnosis or treatment); *People v. LaLone*, 437 N.W.2d 611, 614 (Mich. 1989) (holding that a child's statement of identification made to a psychologist did not fall within Fed. R. Evid. 803(4), because physician's reliance on such information to determine the need for protective measure was not "envisioned by the drafters"); *State v. Gokey*, 574 A.2d 766 (Vt. 1990) (holding child's statements detailing the abuse and identifying the perpetrator inadmissible because these statements were made for the purpose of expert testimony).

¹¹⁰*State v. Oleson*, 443 N.W.2d 8, 10 (S.D. 1989) (Henderson, J., concurring).

¹¹¹*United States v. Iron Shell*, 633 F.2d 77 (8th Cir. 1980), cert. denied 450 U.S. 1001 (1981).

¹¹²*Id.* at 84.

¹¹³*Id.*

¹¹⁴*Id.*

¹¹⁵*Renville*, 779 F.2d 430 (8th Cir. 1985). See also *United States v. Provost*, 875 F.2d 172 (8th Cir. 1989) (holding admissible statements of cause and identification made to a physician and a psychologist by a ten year-old girl).

¹¹⁶*Id.* at 436. See *Morgan v. Foretich*, 846 F.2d 941 (4th Cir. 1988) (accepting *Renville's* judgment that abuse in the home presents a different situation "which requires great caution in excluding highly pertinent evidence").

¹¹⁷406 N.W.2d 385 (Wis. 1987).

Nelson's daughter became distraught over visitations with him. She described several incidents of sexual abuse to her mother, who then carried the child to a psychologist. Over a period of sixty sessions, the child implicated Nelson as a possible abuser.

Nelson's conviction was later affirmed by the United States Court of Appeals for the Seventh Circuit. *Nelson v. Farrey*, 874 F.2d 122 (7th Cir. 1989). This court found that Nelson's right to confrontation had not been violated because statements were sufficiently reliable based on other hearsay evi-

dence which had been admitted without objection. The court further noted that psychologists employ professional skills to elicit truthful statements which, although not infallible, could be considered by a jury. *Id.* at 129.

¹¹⁸Tuerkheimer, *Convictions Through Hearsay in Child Abuse Cases: A Logical Progression Back to Square One*, 72 Marq. L. Rev. 47, 53 (1988).

The psychologist also testified that she asked the child whether she would tell the truth; the child replied "I don't have to tell the truth." *Nelson*, 406 N.W.2d at 396.

¹¹⁹Tuerkheimer, *supra* note 118, at 54.

¹²⁰*Sulka v. State*, 717 P.2d. 394 (Alaska Ct. App. 1986).

¹²¹74 Md. App. 1, 536 A.2d 666 (1988). "This" referred to bruises on the child's body noted by the physician during the physical examination. The child had been brought to the hospital by a protective service worker.

¹²²*Id.* at 680.

¹²³*Id.*

¹²⁴*Id.* at 682 n. 14.

¹²⁵77 Md. App. 20, 549 A.2d 27 (1988).

¹²⁶Francis Scott Key Medical Center is one of three rape centers in the Baltimore area. The pediatric team uses a multidisciplinary approach similar to a child advocacy team.

¹²⁷An examination of the child's vaginal area revealed a blood clot at the hymen, a vaginal opening much larger than the norm for this age, and poor rectal sphincter tone.

¹²⁸Using an anatomically-correct doll, the child identified the penis as a "tutor." She named the girl doll Cindy and the boy doll Cindy's Dad.

¹²⁹*Id.* at 34. The social worker had informed Rachel of the team's concern over the blood in her panties.

¹³⁰The court took notice of the fact that the pediatrician had referred the child to find the source of the bleeding and to obtain a plan for treatment.

About the Author:

Sharon P. O'Neill is an associate at Carr Goodson & Lee in Washington, D.C., specializing in health care issues. She is a member of the Maryland and Washington, D.C. Bars. Ms. O'Neill has a masters in nursing from the University of Pennsylvania and a law degree from the University of Baltimore. Prior to attending law school, Ms. O'Neill worked for three years as a pediatric pulmonary nurse specialist at the Johns Hopkins School of Medicine. The author gives special thanks to Professor Lynn McLain, University of Baltimore School of Law, for her guidance in writing this article.

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